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Independence Plus:
A Program for Family or Individual Directed Community Services Waiver
Section 1915(c) Version

Template for *Independence Plus:* A Program for Family or Individual Directed Community Services §1915(c) Waiver Application

I. State Proposal Information

The State of North Carolina requests approval of a Medicaid Home and Community-Based Services (HCBS) Waiver under the authority of Section 1915(c) of the Social Security Act. The program, to be entitled: **CAP-Choice**. Medicaid beneficiaries to arrange and purchase family and individual supports and related services as described below. The proposed effective date of this waiver program is __July 1, 2003**.** Initial waivers are approved for three years. Renewed waivers are granted for five years.

This is a model waiver:

a. Yes _____ b. No __X____
If yes, the state assures that this waiver will serve no more than 200 individuals at any one time.

Line of Authority for Waiver Operation: (**Note**: Ultimately, the State Medicaid Agency is accountable for the operation of the program, but may allow daily operations to be managed by another entity of state government.) Check one:

___X_ The waiver will be operated directly by the ___Medical Assistance (Division of Medical Assistance, NC Department of Health and Human Services)__ Unit of the State Medicaid Agency/Single State Agency.

_____ Operational management and responsibilities of the waiver will be carried out by _____ (another State Agency) and will be subject to an explicit interagency agreement that ensures for accountability and effective management for all requirements and assurances under this waiver. The single State Agency will retain the responsibilities of issuing policies, rules and regulations concerning this waiver. A copy of the interagency agreement setting forth the specific agency responsibilities and authorities is attached and is made pursuant to Section 1902(a) of the Act and regulations at 42 CFR 431.10 which stipulate the roles and responsibilities of the single State Agency.

II. General Description of Program

III. Assurances

The state provides the following assurances to CMS:

Health & Welfare - Necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. Those safeguards are described in **Appendix B** and include:

A. Adequate standards for all types of providers that furnish services under the waiver;
B. Assurance that applicable state licensure or certification requirements are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements will be met on the date that the services are furnished; and
C. Assurance that all facilities covered by Section 1616(e) of the Social Security Act, in which Home and Community-Based Services will be provided, are in compliance with applicable State standards for board and care facilities. (Refer to 45 CFR Part 1397.)

Check one:

___X_ Home and Community-Based Services will not be provided in facilities covered by Section 1616(e) of the Social Security Act.

_____ A list of facilities covered by 1616(e) of the Social Security Act, in which HCBS are furnished, and a copy of the standards applicable to each type of facility identified above are also maintained by the Medicaid Agency. These facilities

will be used for the limited purpose
of:_____
(Note: For example, respite care only when other services are unavailable.)

Financial Accountability - The state will maintain the financial integrity of the HCBS Waiver program. The State will assure financial accountability for funds expended for Home and Community-Based Services, provide for an independent audit of its waiver program, and will maintain and make available to HHS, the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver, including reports of any independent audits conducted. See Appendix G-3.

Single Audit – The state will conduct a single audit in conformance with the Single Audit Act of 1984, P.L. 98-502.

a. Yes ____X__ b. No _____

Evaluation of Need - The State will provide for an evaluation (and periodic reevaluations, at least annually) of the individuals' need for an institutional level of care, when there is a reasonable indication that individuals might need such services in the near future (one month or less) but for the availability of Home and Community-Based Services. The requirements for such evaluations and reevaluations are detailed in **Appendix D**.

Choice of Alternatives - When an individual is determined to require a level of care provided in a NF, hospital, or ICF/MR, the individual or his or her legal representative will be:

A. Informed of any feasible alternatives under the waiver; and
B. Given the choice of either institutional or Home and Community-Based Services.

The state will provide an opportunity for a fair hearing under 42 CFR Part 431, subpart E, to persons who are not given the choice of home or community-based services as an alternative to institutional care, or who are denied the services(s) of their choice, or providers (s) of their choice, or who are denied the service(s) of their choice, or the provider(s) of their choice.

Average per capita expenditures - The average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures for the level(s) of care, for which this waiver is an alternative, under the State plan that would have been made in that fiscal year had the waiver not been granted. Cost neutrality is demonstrated in **Appendix G**.

Actual total expenditures - The State's actual total expenditures for Home and Community-Based Services and other Medicaid services under the waiver and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100

percent of the amount that would be incurred by the state's Medicaid program for these individuals in the institutional setting(s) for which this waiver is an alternative in the absence of the waiver. Cost-neutrality is demonstrated in **Appendix G**.

Services absent the waiver - Absent the waiver, participants would receive the services appropriate to the level of care typically provided in institutional settings available through the State Plan.

Reporting - The agency will provide CMS annually with information on the impact of the waiver on the type, amount and cost of services provided under the waiver and on the health and welfare of the persons served through the waiver. The information will be consistent with a data collection plan designed by CMS. Reporting is described in **Appendix F-2**

Independent Assessment - The state will provide for an independent assessment of its waiver that evaluates the quality of care provided, access to care, and cost-neutrality. The results of the assessment will be submitted to CMS at least 90 days prior to the expiration of the approved waiver period and cover the first 24 months (new waivers) or 48 months (renewal waivers) of the waiver.

IV. Waivers Requested

Statewideness: The state requests a waiver of the "Statewideness" requirements set forth in Section 1902(a)(1) of the Act.

_____ No. Services will be available Statewide.
__X__ Yes. Waiver services will be furnished only to individuals in the following geographic areas or political subdivisions of the State (Specify):
The geographic areas where the waiver will operate are being selected through a request for proposal process and will be submitted to CMS prior to the end of the initial 90-day review period.

Comparability: The State requests a waiver of the requirements contained in Section 1902(a)(10)(B) of the Act, to provide services to individuals served on the waiver that are not otherwise available to other individuals under the approved Medicaid State Plan.

Income and Resources: The state requests a waiver of 1902(a)(10)(C)(i)(III) of the Social Security Act in order to use institutional income and resource rules for the medically needy.

_____X____ Yes _____ No _____ N/A

V. State Specific Elements

A. Levels Of Care: This waiver is requested to provide Home and Community-Based Services (HCBS) to individuals who, but for the provision of such services, would require the following levels (s) of care, the cost of which could be reimbursed under the approved Medicaid State plan: (check all that apply)

_____ Hospital
___X_ Nursing Facility
_____ ICF/MR

Waiver services will not be furnished to individual who are inpatients of a hospital, Nursing Facility or ICF/MR.

N/A ___Waiver services are limited to individuals who are mentally retarded or DD, who currently reside in general Nursing Facilities, but who have been shown, as a result of Pre-Admissions Screening and Annual Resident Review process mandated by P.L. 100-203 to require active treatment at the level of an ICF/MR.

B. Room and Board: FFP will not be claimed in expenditures for the cost of room and board, with the following exceptions(s): (Check all that apply)

___X__ When provided as part of respite care in a facility approved by the state that is not a private residence (hospital, NF, foster home, or community residential facility).

_____ Meals furnished as part of a program of adult day health services.

_____ When a live-in personal caregiver (who is unrelated to the individual receiving care) provides approved waiver services, a portion of the rent and food that may be reasonably attributed to the caregiver who resides in the same household with the waiver recipient. FFP for rent and food for a live-in caregiver is not available if the recipient lives in the caregiver's home, or in a residence that is owned or leased by the provider of Medicaid services. An explanation of the method by which room and board costs are computed is included in Appendix G-3.

For the purposes of this provision, "board" means 3 meals a day, or any other full nutritional regime.

C. Target Population: A waiver of Section 1902(a)(10)(B) of the Act is requested to limit Home and Community-Based Services waiver services to select groups of individuals who would be otherwise eligible for waiver services. The target groups are indicated below:

1. Target group per 42 CFR 441.301(b)(6) – Check all disability and age categories that apply. (**Note:** Current regulations governing §1915(c) waivers do not allow persons under age 65 with mental retardation or developmental disability – and no concurrent physical disability – to be served in a waiver that serves persons with physical disabilities only. Combining populations under the §1115 Demonstration authority is allowable.)

Category	**CHILDREN AGE RANGE**		**ADULTS AGE RANGE**		**AGED AGE RANGE**
	From	**To**	**From**	**To**	**From**
Aged only					65 & Older
Disabled (Physical)			18	65	
Disabled (Other)			18	65	
Brain Injury (Acquired)					
Brain Injury (Trauma)					
HIV/AIDS					
Medically Fragile					
Technology Dependent					
Autism					
Developmental Disability					
Mental Retardation					
Mental Illness					

2. States have the discretion to further define these target groups (Reference Section 1902(a)(10)(B).). If the state wishes to further define, please describe below:

Waiver services are limited to individuals residing in private residential settings.

3. The state selects the following option regarding individual cost limits:

_____ A. No otherwise eligible individual will be denied services or enrollment in the waiver solely because the cost of the individual's Home and Community-Based Services exceeds the average institutional Medicaid payment for the applicable level of care.

___X___ B. Otherwise eligible individuals may be denied home or community-based services if the agency reasonably expects that the cost of the Home and Community-Based Services would exceed the cost of an equivalent and applicable level of institutional care, pursuant to 42 CFR 441.301(a)(3). The state selects the following method to calculate these costs:

_____ **Individualized Computation.** The Medicaid cost of the individual's service plan is compared to the cost of serving *this particular individual* in the institutional setting.

___X_ **Mathematical Average.** The Medicaid cost of the individual's service plan will be compared to the state's average per capita cost of applicable institutional care at 100% of the institutional average or a level higher than 100% (**the same percentage used for the hcbs waiver program, CAP/DA, which serves this population, currently at 87% of the average per capita cost of NF care** _____%). Further, the limit will be calculated on the basis of:

_____x____ 1) Level of care
_____ 2) Diagnosis or condition

D. Medicaid Eligibility: All eligibility groups included under this waiver are covered in the State Plan. The state will apply all applicable FFP limits under the plan.

1. ***Eligibility Criteria***: Specify whether the state uses the eligibility criteria used by the Supplemental Security Income (SSI) program or whether it uses more restrictive eligibility criteria than those of the SSI program for aged, blind, and disabled individuals: (check one):

___X_ SSI Criteria or 1634 State. The state uses SSI criteria.

____ 209(b) State. The state uses more restrictive eligibility criteria for aged blind, and disabled individuals than the criteria used under the SSI program.

2. ***Eligibility Groups Served*:** Individuals receiving services under this waiver are eligible for Medicaid under the following eligibility groups: (check one):

a. __X__ All eligibility groups covered in the State plan are included under this waiver.
b. _____ Only the following groups covered under the State plan are included under this waiver. (Check all that apply:)

1. _____ Low-income families with children as described in Section 1931 of the Social Security Act.
2. _____ SSI Recipients
3. _____ Aged, blind or disabled who are eligible under 42 CFR 435.121
4. _____ Medically needy (A waiver of Section 1902(a)(10)(C)(i)(III) of the Social Security Act is requested to use institutional income and resource rules for the medically needy.)
5. _____ All other optional and mandatory groups under the plan except for those individuals who would be eligible for Medicaid only if they were in an institution).
6. _____ Individuals who would be eligible for Medicaid only if they were in an institution
7. _____ Individuals who would only be eligible for Medicaid, without spend down income, if they were living in a hospital, NF or ICF/MR. (Check one:)

_____ All Individuals
_____ Limited to:
A special income level equal to:
_____ 300% of the SSI Federal Benefit Rate (FBR), OR
_____ %, a percentage lower than 300% of FBR, OR
$____ a specific amount that is lower than 300% of FBR
_____ Aged blind and disabled who meet requirements that are more restrictive than those in the SSI program
(Please explain:_____
_____
_____ Medically needy without spend down
_____ Other: _____

3. Spousal Impoverishment Protection: Spousal impoverishment rules may be used for determining eligibility for the special Home and Community-Based Waiver eligibility group at 42 CFR 435.217 for individuals who have a spouse residing in the community. Further, these rules may apply to the post-eligibility treatment of income.

The State will use spousal impoverishment rules for determining income:
__X__ Yes ____ No

The State will use spousal impoverishment rules for the post-eligibility treatment of income:
_____ Yes ___X__No

E. Services: The state requests that the following Home and Community-Based Services, as set forth in 42 CFR 440.180, be included under this waiver (Check all that apply here and define in **Appendix B**): (**NOTE:** All services must meet applicable regulatory standards and CMS policy guidance. Refer to **Appendix B** for new self-directed service descriptions.)

Check all that apply:

Service	Family or Individual Directed Method	Provider or Other Service Delivery Method
Case Management		
Homemaker Services		
Home Health Aide Services		
Personal Care Services Attendant Services(may include Attendant Care)		
Adult Day Health Services		**X**
Habilitation Services		
Respite Services: **In-Home** **Institutional**	**X**	**X** **X**
~~Supports Brokerage Services/Functions~~ (Required) **(Care Advice)**		**X**
Financial Management Services Services/Functions (Required)		**X**
Other (Describe in Appendix B) **Below:**		
Personal Assistant	**X**	

Services		
Telephone Alert, Home Delivered Meals, In-Home Aide Services		**X**
Home Mobility Aids, Waiver Supplies	**X**	**X**
Consumer-Designated Goods & Services	**X**	

VI. Cost-neutrality

The state has provided the supporting information/data to demonstrate cost neutrality in **Appendix G**.

VII. Additional Requirements

A. Plan of Care: A written plan of care will be developed for each individual under this waiver utilizing a family or person-centered planning process that reflects the needs and preferences of the individual and his or her family. The state's procedures governing the plan of care and the utilization of family or person-centered planning are included in **Appendix E**.

(**Note**: Family or person-centered planning is a process, directed by the family or the individual with long-term care needs, intended to identify the strengths, capacities, preferences, needs and desired outcomes of the individual. The family or individual directs the family or person-centered planning process. The process includes individuals freely chosen by the family or individual who are able to serve as important contributors. The family or person-centered planning process enables and assists the individual to identify and access a personalized mix of paid and non-paid services and supports that will assist him/her to achieve personally-defined outcomes in the most inclusive community setting. The individual identifies planning goals to achieve these personal outcomes in collaboration with those that the individual has identified, including medical and professional staff. (The identified personally-defined outcomes and the training, supports, therapies, treatments and/or other services the individual is to receive to achieve those outcomes become a part of the plan of care.)

All services will be furnished pursuant to a written plan of care.

This plan of care will describe the services and supports (regardless of funding source) to be furnished, their projected frequency, and the type of provider who will furnish each.

The plan of care will address how potential emergency needs of the individual will be met.

The plan of care will be subject to the approval of the Medicaid Agency.

FFP will not be claimed for waiver services furnished prior to the development of the plan of care or services that are not included in the individual written plan of care.

B. Individual Budgets:

(**NOTE:** Individual budgets include the value of the waiver services available to the family or individual to support the individual's plan of care. Only waiver services as defined by the state are included in the individual budget. This amount of money designated in the budget is established by a methodology determined by the state and the amount is agreed upon with the family or individual.)

Check one:

__X__ The state has established a uniform methodology by which all individual budgets in the waiver will be calculated. The methodology is described in **Appendix H**. (**Note**: Minimum requirements of the methodology are that the budget is built upon actual service utilization and cost data, the methodology is described to the individual and their family, the methodology is open for inspection by authorized public entities including, but not limited to CMS, and there is a process for re-determination.)

_____ The state has established a minimum set of criteria and an approval process for methodologies developed by subcontractors, counties or other entities with which the state has contracted for the day-to-day operation of the waiver. The criteria by which individual budget methodologies will be reviewed and the approval process is described in **Appendix H**. (**Note**: Minimum requirements of the methodology are that the budget is built upon actual service utilization and cost data, the methodology is described to the individual and their family, the methodology is open for inspection by authorized public entities including, but not limited to, CMS, and there is a process for re-determination.

Although the Medicaid Agency may contract with another agency or organization for the daily operation of the waiver program, it must retain the authority to issue policies, rules and regulations related to the waiver.)

C. Provider Selection: Families and individuals will have flexibility to select qualified providers within the criteria established by the state. The criteria are described in **Appendix B.**

D. Plan of Care Management: Families and individuals will have the ability to direct the services and supports identified in the plan of care within the resources available in the established individual budget. Families will have maximum possible flexibility in the utilization of resources delineated in the plan of care and individual budget consistent with the requirement to maintain public accountability. The state's description of how families may flexibly use resources while the State continues to assure health and welfare is described in **Appendix E**.

(Note: As determined by the state, families and individuals may have the ability to move resources among and between all or some of the services contained in the plan of care without a formal plan of care revision. Families or individuals might have full discretion to manage all of the plan or only parts of it. For example, the family or individual might manage the homemaker services, but not the habilitation services.)

E. Participant Protections: The state assures that each of the protections below is in place and described in **Appendix I**.

The state has procedures to assure that families and individuals requesting services have the requisite information and/or tools to participate in a family or person-centered planning approach and to direct and manage their care as outlined in the individual plan of care. The state will make available and provide services such as assistance in locating and selecting qualified workers, training in managing workers, completing and submitting paperwork associated with billing, payment and taxation. Supports Brokerage and Financial Management Services Services/Functions are required and should be provided by one or more entities. The services and the provider qualifications are described in **Appendix B**.

Upon family or individual request, the state makes available, at no cost, provider qualification checks, including criminal background checks. (Note: Provider qualifications for each service are described in **Appendix B**.)

The State has procedures to promote family and individual preferences and selections and these are balanced appropriately with accepted standards of practice. This balance requires deference to the individual's preferences whenever possible. Procedures will include individual risk

management planning, where applicable (e.g., risk agreements or informed consent contracts) to ensure that family or individual decisions are honored.

The state has a system in place for assuring emergency back-up and/or emergency response capability in the event those providers of services and supports essential to the individual's health and welfare are not available. The state should define and plan for emergencies on an individual basis, the state also must have system procedures in place.

The state has procedures for how it will work with families or individuals and their Financial Management Services (if applicable) to monitor the ongoing expenditure of the individual budget.

The state has procedures for how it will respond to situations where this ongoing monitoring has failed to prevent the expenditure of the individual budget in advance of the re-determination date. These procedures are to assure that services needed to avoid out-of-home placement and the health and welfare of the individual are available.

The state has procedures for how decisions will be made regarding unexpended resources at the time of budget re-determination.

F. Quality Assurance & Improvement:

The state, through a formal quality assurance program, will provide appropriate oversight and monitoring of its HCBS Waiver program to ensure that each of the assurances contained in this application is met and to continually improve the operation of the program. The program will involve families or individuals in the process of assessing and improving quality. Details of this process are found in **Appendix F** of this request. The state further assures that all problems identified through this monitoring will be addressed in an appropriate and timely manner, consistent with their severity and nature and will contain an incident management system to address critical events.

G. Contact Person: The State Medicaid Agency Representative that CMS may contact with questions regarding the waiver request is:

Name: Judy Walton

Title: Policy Analyst/Program Administrator

Agency: North Carolina Division of Medical Assistance

Address: 2517 Mail Service Center, Raleigh, NC 27699-2517

Telephone: 919/857-4244

E-mail: judy.walton@ncmail.net

H. Authorizing Signature: This document, together with Appendices A through I, and all attachments, constitutes the state's request for *Independence Plus:* A Program for Family or Individual Directed Community Services Home and Community-Based Services Waiver under Section 1915(c) of the Social Security Act. The state affirms that it will abide by all provisions of the waiver (including Appendices and Attachments), and certifies that any modifications to the waiver request will be submitted in writing by the State Medicaid Agency in the form of waiver amendments. Upon approval by CMS, this waiver request will serve as the State's authority to provide Home and Community-Based Services to the target group under its Medicaid plan.

The state assures that all material referenced in this waiver application (including standards, licensure and certification requirements) will be kept on file at the Medicaid Agency.

(**Note:** The request must be signed by the Governor, Single State Agency or Medicaid Director, or a person within the State Medicaid Agency with the authority to sign on behalf of the state.)

Signature:
Print Name:
Title:
Date:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this collection is 0938-0449. The time required to complete this information collection is estimated to average 160 hours for each new and renewed waiver and includes searching existing data resources, gathering the data needed, and completing and reviewing the information collection. If you have any comments concerning the accuracy of the time estimates or suggestions for improving this form, please write to: CMS, P.O. Box 26684, Baltimore, Maryland 210207 and to the Office of Information and Regulatory affairs, Office of Management and Budget, Washington, D.C. 20503.

North Carolina - May 2003

APPENDIX A – DESCRIPTION OF THE WAIVER PROGRAM

I. Purpose and Description of the Proposal:

Background/Purpose:
CAP Choice is a program of consumer-directed care for elderly and disabled adults who wish to remain at home and have increased control over their services and supports. The State of North Carolina has operated a home and community based services waiver, the Community Alternatives Program for Disabled Adults (CAP/DA), since 1983 which currently serves approximately 9600 seniors and disabled adults. The program has been successful in meeting the long-term care needs of these populations but the State recognizes that some participants would prefer to select their individual workers, more fully direct their care and have more flexibility in tailoring plans of care to their home care requirements. Under CAP Choice, consumers will be able to:

- **Choose (hire) the Personal Assistant who will provide their care**
- **Train, supervise and evaluate the worker**
- **Negotiate the rate of pay and other benefits**
- **Release the worker should this become necessary**
- **Select individual providers and direct reimbursement for several waiver services**
- **Engage in a cooperative working arrangement with a financial manager who will pay the client's worker; handle federal/state taxes and other payroll or benefits related to the employment of the worker; and reimburse other service providers under the direction of the participant**

The goals of the program are to increase consumer choice and independence in meeting home care needs; increase satisfaction with long term supports; develop a system that both supports responsible stewardship of public dollars and provides safeguards to ensure personal security and well being of participants who opt for consumer-directed care; and reduce unnecessary bureaucratic intervention and expense in the delivery of services. CAP Choice will be piloted in a limited number of geographic areas but will ultimately be available statewide and will operate alongside or as a component of the traditional waiver program for this population, CAP/DA.

Administration:
The Division of Medical Assistance will directly administer CAP Choice and the program will be coordinated locally through "lead agencies," which function as the local entry points for CAP/DA and provide local oversight. Lead agencies include departments of social services, health departments, aging agencies and hospitals. The lead agencies will provide both Financial Management and Care Advice services and will manage and disburse consumer-directed funds.

Eligibility:

To be eligible for CAP CHOICE an individual must:

- **Live in the geographic areas where CAP CHOICE is available**
- **Meet basic criteria to be assessed for hcbs waiver participation, e.g., at risk of institutional care**
- **Be eligible for Medicaid**
- **Understand the rights and responsibilities of directing one's care and be willing to self-direct or select a representative who is willing and capable of assuming this responsibility**

In the following situations, participation in CAP Choice will require that a representative be designated: based on the assessment, it is determined that the applicant is unable to make decisions independently due to impaired mental processes; or, the applicant has a court-appointed legal guardian or designated payee of income.

Representative:

The representative may be a family member, friend, legal guardian, other legally appointed representative, or income payee. The representative cannot be paid for the service and must meet the following requirements:

- **Demonstrate knowledge and understanding of the participant's needs and preferences**
- **Agree to a predetermined level of contact with the participant**
- **Be willing and able to comply with program requirements**
- **Be at least 18 years of age**
- **Be approved by the participant to act in this capacity**

Care Advisor Role:

The care advisor is a specialized case manager with an understanding of consumer-directed care and the ability to facilitate rather than direct care planning and service delivery. Care Advisors are registered nurses and social workers who meet the standards described in Appendix B.

The care advisor assists the Consumer in assessing need and developing a Plan of Care including a consumer-directed budget. The care advisor also provides orientation and training on consumer-directed care to the participant and/or participant's representative or family members as appropriate. The advisor monitors the provision of care and expenditures and maintains contact with the participant to assure that the needed care is being provided. The care advisor is also responsible for identifying the need for a representative and assuring that representatives meet the criteria outlined above.

Participant Role:

The role of participants is greater in CAP Choice than in the traditional program, in that they have significantly more control over resources. With this increased control comes increased responsibility. The key responsibilities of the Consumer are:

- **Develop a plan of care with assistance/support from the care advisor**

- **Recruit, hire, and manage Personal Assistant and other individual providers of consumer-directed services**
- **Prepare an outline of duties and work schedule for Personal Assistant**
- **Notify Assistant of any changes in schedule in a timely manner**
- **Train and evaluate Assistant**
- **Negotiate reimbursement or payment rates with individual providers**
- **Develop a back-up/emergency plan (alternative caregivers)**
- **Serve as employer of record for Personal Assistant**
- **Verify accuracy of documentation or provide documentation, as appropriate, to FM regarding services provided**
- **Report concerns to Care Advisor about service delivery or representative that affect health and well-being**
- **Uphold all program agreements as written**

FM Role:
The Financial Manager bills for consumer-directed care services in the individual plan and disburses funds. The FM:

- **Files claims through the MMIS**
- **Reimburses individual providers**
- **Makes required payroll deductions**
- **Conducts criminal background checks and verifies age of Personal Assistants**

FM services will be provided by each local lead agency overseeing program activities. There are many advantages to the lead agencies acting in this capacity, i.e., lead agencies are experienced in providing oversight for CAP/DA; they are experienced in billing through the MMIS, e.g., for case management; lead agencies oversee program case managers/care advisors which will facilitate communication between the two; and lead agencies are experienced in working with waiver participants.

Use of Funds:
Participants will have a one-year budget to purchase items or services designated as consumer-directed in the plan of care. (Services which may be directed by the consumer include Personal Assistant, Mobility Aids, Waiver Supplies, In-Home Respite, and Consumer-Directed Goods and Services.) The amount budgeted will be based on assessed need as described in Appendix H. The Consumer will be able budget for nontraditional goods and services, called Consumer Directed Goods and Services, which are approved only if related to care needs as described in Appendix B. Funds for Consumer-Directed Goods and Services will be maintained in an account by the FM to pay for the items or services when purchased. Payment for all consumer-directed services will require documentation such as time sheet or invoice. The Consumer will be able to substitute consumer-directed services within the Plan as long as the changes continue to address the

individual's ADL/IADL needs. The Consumer must keep the care advisor and FM informed of adjustments or substitutions.

Termination from the Consumer-Directed Program:
Plans of Care and service provision will be continually monitored by the care advisor to see that needs are met and funds are utilized according to program criteria. If problems in these areas are identified, the care advisor will work with the Consumer to resolve them. If they cannot be resolved, the Consumer will be removed from this program and assessed for the traditional hcbs program, CAP/DA. Care advisors/lead agencies will consult with DMA program consultants prior to taking this action.

II. Type of Submission: (check one:)

Model Waiver
New Waiver (3 year term) X
Renewal Waiver (5 year term)

III. Title of the Program:
CAP CHOICE

IV. Self-Direction Support Provisions:

A. ~~Supports Brokerage~~ Care Advice Activities:

1) Activities to be Performed: Assist with development of plan of care and emergency/back-up plan; provide information and skills training to consumer/consumer's representative; provide worker orientation to consumer-directed care; monitor plan of care for quality assurance purposes.

2) Specific Responsibilities: The care advisor is a facilitator and provides information and education to the consumer about home care and employing and supervising workers. The advisor, for example, might provide guidance in recruiting workers but does not recruit workers *for* the consumer. The advisor is also responsible for local oversight of the plan.

3) Reimbursement Process (check one:)

a. HCBS Waiver Services (defined in Appendix B:) X

b. Administrative Activities:

4) State Oversight Responsibilities:

a. Who Will Provide Oversight/Monitoring? Care advisors will be specialized case managers employed and supervised by the lead agency. State Medicaid waiver program consultants will continue to oversee the lead agencies and their waiver program activities.

b. Method and Frequency of Oversight/Monitoring: Waiver program consultants from the State Medicaid agency conduct on-site program reviews and assist advisors otherwise on an as-needed basis.

B. Financial Management Services:

1) Activities to be Performed: Bill MMIS for consumer-directed services in the approved plan of care and manage client accounts; disburse funds to individual providers while withholding appropriate deductions; conduct criminal background checks and age verification on Personal Assistants.

2) Specific Responsibilities: The Consumer is the employer of record; the Financial Manager (FM) provides mandatory technical assistance to assure that appropriate taxes and fees are deducted and funds are disbursed appropriately. The FM is responsible for obtaining verification from the Consumer of services performed before initiating payment. The FM is not responsible for any reimbursement errors due to inaccurate reporting by the Consumer.

3) Reimbursement Process (check one:)

a. HCBS Waiver Services (defined in Appendix B:) X

b. Administrative Activities:

4) State Oversight Responsibilities:

a. Who Will Provide Oversight/Monitoring? The lead agencies for local operation of the traditional hcbs waiver program, CAP/DA, will provide FM services. State Medicaid waiver program consultants will continue to oversee the lead agencies and their waiver program activities.

b. Method and Frequency of Oversight/Monitoring: Waiver program consultants from the State Medicaid agency conduct annual, on-site program reviews and assist/advise with local operation of the waiver program as needed.

Direct Payment to Provider Agreement: <u>The lead agencies will be designated as Organized Health Care Delivery Systems (OHCDS); they will provide care advice and FM services directly and all consumer-directed services indirectly or by subcontract.</u>

VI. Employer of the Worker:

A. Who is Responsible for Payroll Tasks? <u>The FM Agency.</u>

B. Who is considered the Common Law Employer (Employer of Record)? <u>The Consumer.</u>

C. Who is considered the Managing Employer? <u>The Consumer manages and supervises the *worker and the work schedule* and the FM Agency manages funds disbursement based upon consumer report of work performed and federal, state, and local tax withholding requirements.</u>

APPENDIX B - SERVICE DEFINITIONS, STANDARDS AND PROVIDER QUALIFICATIONS

A. SERVICE DEFINITIONS, STANDARDS & PROVIDER QUALIFICATIONS CHARTS

For each service that was checked under State Specific Elements/Services of the template, the following chart must be completed. Each chart provides the state's service definition, outlines the provider qualifications and standards, and the service delivery method that govern the provision of each service under the waiver.

Provider qualifications are expected to vary by the type of service being provided or managed. For those services which there is a uniform State license or certification requirement, the legal citation is provided. For state defined standards other than those governed by State law, the standards are attached. Either the family or individual or the state Agency may manage some services. For example, the family or individual might have self-directed support services which include personal care type arrangements. The state may also have personal care services provided by an agency. The provider requirements might be different under these two arrangements. However, the differences must be explained.

For those services that are available in the State Plan, the description must include those aspects of the service that go beyond the State Plan coverage. (**Note:** For example, if personal care services are included in the State Plan, personal care services provided under the scope of the waiver must differ in amount, scope, supervision arrangements or provider type **or** be utilized only when the State Plan coverage is exhausted.)

The state has the authority to request that the Secretary approve "other" services identified by the state as cost neutral and appropriate to avoid institutionalization. Each "other" service defined by the state must be separately identified and defined and the provider qualifications must be included.

For each service for which standards other than, or in addition to state licensure or certification must be met by providers, the applicable educational, professional, or other standards for service provision or for service providers are attached to this Appendix, tabbed and labeled with the name of the service(s) to which they apply.

When the qualifications of providers are set forth in state or Federal law or regulation, it is not necessary to provide copies of the applicable documents. However, the documents must be on file with the State

Medicaid Agency, and the licensure and certification chart at the head of this Appendix must contain the precise citation indicating where the standards may be found.

Service/Function Definitions Not Described Elsewhere:

Supports Brokerage: Service/function that assists participating families and individuals to make informed decisions about what will work best for them are consistent with their needs and reflect their individual circumstances. Serving as the agent of the family or participant, the service is available to assist in identifying immediate and long-term needs, developing options to meet those needs and accessing identified supports and services. A family or person-centered planning approach is used. Supports Brokerage offers practical skills training to enable families and individuals to remain independent. Examples of skills training include providing information on recruiting and hiring personal care workers, managing personal care workers and providing information on effective communication and problem-solving. The service/function includes providing sufficient information to assure that participants and their families understand the responsibilities involved with self-direction and assist in the development of an effective back-up and emergency plan. States may elect to fulfill the requirement of this service/function using a self-directed case manager or creating a distinct service. States may elect to fulfill this required service/function either as a service cost or an administration cost, but must clearly identify which method will be used. The services/functions included in Supports Brokerage are mandatory requirements of the template.

Financial Management Services: Service/function that assists the family or individual to manage and direct the distribution of funds contained in the individual budget including. This may include the facilitation of the employment of service workers by the family or individual including Federal, state, and local tax withholding/payments, unemployment compensation fees, wage settlements, fiscal accounting and expenditure reports. States may elect to fulfill this required service/function either as a service or an administrative cost, but must clearly identify which method will be used. This service/function, regardless of provider or method, must be delivered under a family or person-centered planning process and is a requirement of the template.

Other Services: Services appropriate to ensure the health and welfare of individual participants and, in conjunction with other services, serve as an alternative to institutionalization.

Service Title	**Adult Day Health Services**
Service Definition	**This service is care for the client in a certified Adult Day Health Care facility. The care is for aged, disabled, and handicapped adults who need a structured day program of activities and services with nursing supervision. It is an organized program of services during the day in a community group setting. The program supports the adult's independence and promoted social, physical, and emotional well-being. Services include health services and a variety of program activities designed to meet the individual needs and interests of the clients, and referral to and assistance in using appropriate community resources. Food and food services include a nutritional meal and snacks as appropriate.**
Provider Requirements	**Certified Adult Day Health Care Facilities**
State License	**N/A**
Certification	**Certified according to NC General Statute 131-D-6. Certification process is conducted by NC Division of Aging under NC Administrative Code Title 10, Chapter 42, Subchapter 42E and 42Z. As provided under Subchapter 42S, local departments of social services are responsible for ongoing monitoring and annual recertification.**
Other Requirements or Standards	**N/A**
Describe Service Delivery Method (Agency or Self-directed)	**Provider-Directed**

Service Title	**Care Advisor**
Service Definition	**Care Advice focuses on empowering consumers to define and direct their own personal assistance needs and services; the Care Advisor guides and supports, rather than directs and manages, the Consumer throughout the service planning and delivery process. A plan of care is developed which contains both paid and unpaid services and supports needed by the Consumer to live successfully in the home and community. A back-up plan is also developed to assure that the needed assistance will be provided if any key supports identified in the Plan are temporarily unavailable. The Care Advisor provides the information and skills training needed to manage one's own care in the areas of rights and responsibilities of both the Consumer and Worker; recruiting and hiring workers; developing schedules and outlining duties; supervising and evaluating workers; reporting on personal assistance expenditures; and other relevant information and training.**
Provider Requirements	**Care Advice is considered specialized Case Management and must be provided by CAP/DA lead agencies or their designee.**
State License	**Nurse case management/care advice must be provided by a registered nurse (RN) licensed by the State Board of Nursing to practice in NC.**
Certification	**N/A**
Other Requirements or Standards	**Case managers/care advisors must meet the requirements of the NC Office of State Personnel for Public Health Nurse I or higher or Social Worker I or higher.**
Describe Service Delivery Method (Agency or Self-directed)	**Provider-Directed**

Service Title	**Financial Management Services**
Service Definition	**Financial Management Services are provided to assure that consumer-directed funds outlined in individual plans of care are managed and distributed as intended. The Financial Manager (FM) files claims through the MMIS for consumer-directed goods and services and reimburses individual providers. The FM deducts all required federal, state and local taxes, including unemployment fees, prior to issuing reimbursement or paychecks. The FM entity is responsible for maintaining separate accounts on each Consumer's Personal Assistant Services funds and producing expenditure reports as required by the State Medicaid agency. The FM conducts criminal background checks and age verification on Personal Assistants.**
Provider Requirements	**CAP/DA Lead Agency or its designee**
State License	**N/A**
Certification	**N/A**
Other Requirements or Standards	**Demonstrated capability to act in a fiduciary capacity, file claims accurately, and provide payroll and other reimbursement services.**
Describe Service Delivery Method (Agency or Self-directed)	**Provider-Directed**

Service Title	Home Mobility Aids
Service Definition	Items provided to give the client mobility, safety, and independence in the home. The service is necessary to avoid institutionalization. Though the aids often require minor renovations or physical adaptation of the client's home, this service may not be used to pay for major home renovations or repairs. The service is limited to that needed to adapt the individual's home environment to his/her specific disabilities, and are not items that have general utility to non-impaired individuals. The specific items covered as home mobility aids are: wheelchair ramps; safety rails; grab bars; non-skid surfaces; handheld showers; widening of doorways for wheelchair access for waiver participants.
Provider Requirements	Equipment providers and installers
State License	N/A
Certification	N/A
Other Requirements or Standards	DMA places a limitation on the annual total amount that may be spent for all aids during a period of one year.
Describe Service Delivery Method (Agency or Self-directed)	May be Consumer or Provider-Directed

Service Title	In-Home Aide Services
Service Definition	Assistance with personal care and basic home management tasks for individuals who are unable to perform these tasks independently due to physical or mental impairments. Personal care is help with activities such as bathing, dressing and grooming. Home management is assistance with tasks such as light housekeeping, laundry and meal preparation. The service includes two levels – In-Home Aide Level II and In-Home Aide Level III-Personal Care as defined by the North Carolina Department of Health and Human Services. The levels relate to the complexity of the assistance provided, with the higher level providing care for clients with more complex needs. In-Home Aide Level I, which consists entirely of home management tasks, are covered when provided in conjunction with Level II or Level III-Personal Care tasks. If Level II or Level III-Personal Care tasks are needed, the aide must do the Level I tasks while in the home to provide the higher level services. Typical Level I tasks include paying bills as directed by the client; essential shopping, cleaning and caring for clothing; performing basis housekeeping tasks such as sweeping, vacuuming, dusting, mopping and washing dishes; identifying medications for the client; providing companionship and emotional support; preparing simple meals; and shopping for food.
Provider Requirements	Home care agencies licensed by the State of NC
State License	Home care agencies licensed by the State of North Carolina under NC General Statute 131E-135 through 142 and in accordance with Title 10 of the North Carolina Administrative Code (10 NCAC 31.0900 - .1400)
Certification	N/A

Other Requirements or Standards	**Workers providing Level III – Personal Care tasks must be certified as a Nurse Aide I.**
Describe Service Delivery Method (Agency or Self-directed)	**Provider-Directed**

Service Title	**Personal Assistant Services**
Service Definition	**The Personal Assistant provides help with personal and home maintenance tasks to individuals unable to meet these needs independently due to physical or mental impairments. Personal maintenance tasks are basic daily living activities that must be performed to assure or support one's physical well-being. Examples of personal maintenance tasks are bathing, dressing, eating, completing transfers and moving about as needed in one's environment. Home maintenance involves basic activities that help to promote a safe and healthful living environment such as vacuuming, cooking, and shopping for groceries. Both personal and home maintenance tasks are activities that can generally be performed independently by adults without physical or mental impairments and are activities that must be carried out to enable the Consumer to continue living at home.**
Provider Requirements	**Individual worker must be 18 years of age or older and undergo criminal background check.**
State License	**N/A**
Certification	**N/A**
Other Requirements or Standards	**On-the-job training based on the needs identified in the plan of care will be provided by the Consumer**
Describe Service Delivery Method (Agency or Self-directed)	**Consumer-Directed**

Service Title	**Preparation and Delivery of Meals**
Service Definition	**This service is often referred to as "Meals on Wheels" and provides for the preparation and delivery to the client's home of one nutritious meal per day. Special diets may be included.**
Provider Requirements	**Agencies/organizations which meet NC Division of Aging requirements for home delivered meals**
State License	**N/A**
Certification	**N/A**
Other Requirements or Standards	**Must be in compliance with standards set by the NC Division of Aging for home delivered meals.**
Describe Service Delivery Method (Agency or Self-directed)	**Provider-Directed**

Service Title	**Respite Services – In-Home**
Service Definition	**Services provided to individuals unable to care for themselves, furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care.**
Provider Requirements	**Individual worker must be 18 years of age or older and undergo criminal background check.**
State License	**N/A**
Certification	**N/A**
Other Requirements or Standards	**On-the-job training based on the needs identified in the plan of care will be provided by the Consumer. If provided through a home care agency and Level III - Personal Care tasks are needed, the worker must be certified as a Nurse Aide I.**
Describe Service Delivery Method (Agency or Self-directed)	**May be Consumer or Provider-Directed**

Service Title	**Respite Services – Institutional**
Service Definition	**Services provided in a Medicaid certified nursing facility or a hospital with swing beds. The provider must be enrolled with DMA as a provider of respite for CAP/DA or CAP Choice to individuals unable to care for themselves and**

	who need service on a short-term basis because of the absence or need for relief of those persons normally providing the care. This service may be used to meet a wide variety of needs including family or caregiver emergencies and planned special occasions when the caregiver needs to be away from town for some extended period of time.
Provider Requirements	**Medicaid certified nursing facilities and hospitals with swing beds**
State License	**Nursing facilities licensed under NC Administrative Code Title 10, Chapter 3, Subchapter 3H; and Hospitals licensed under NC Administrative Code title 10, Chapter 3, Subchapter 3C**
Certification	**Certified by the Division of Facility Services**
Other Requirements or Standards	
Describe Service Delivery Method (Agency or Self-directed)	**Provider-Directed**

Service Title	**Telephone Alert**
Service Definition	**Electronic device which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals. Telephone Alert is limited to those individuals who live alone, or are alone significant parts of the day, and have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.**
Provider Requirements	**Must have capability to provide 24-hour monitoring system in accordance with service definition.**
State License	**N/A**
Certification	**N/A**
Other	**N/A**

Requirements or Standards	
Describe Service Delivery Method (Agency or Self-directed)	**Provider-Directed**

Service Title	**Waiver Supplies**
Service Definition	**Supplies provided to the waiver participant to promote the health and well-being of the individual. The service is necessary to avoid institutionalization. The following items are included. They are not covered under the State Medicaid Plan.** **Nutritional supplements taken by mouth when ordered by a physician; reusable incontinence undergarments, disposable liners for reusable incontinence undergarments, and incontinence pads for personal undergarments; and medication dispensing boxes. These are boxes with compartments that can be pre-filled to proportion doses of medication for specific times and days so that the client can independently take the medication or an individual can safely assist the client in the taking of the medication.**
Provider Requirements	**Medical suppliers**
State License	**N/A**
Certification	**N/A**
Other Requirements or Standards	**Supplies must be of sufficient quality and appropriate to the needs of the client.**
Describe Service	**May be Consumer or Provider-Directed**

Delivery Method (Agency or Self-directed)	

Service Title	**Consumer-Designated Goods & Services**
Service Definition	**Services, equipment or supplies not otherwise provided through this waiver or through the Medicaid State Plan that meet the following requirements: the item or service would increase the individual's ability to perform ADLs or IADLs *OR* increase the consumer's safety in the home environment; *AND* the item or service would decrease dependence on Personal Assistant Services or other Medicaid funded services; *AND* the consumer does not have the funds to purchase the item/service. Consumers may direct the FM (through the approved plan of care) to save a portion of their monthly consumer-directed budget for these items/services.**
Provider Requirements	**Items/services must be in the approved plan of care.**
State License	**N/A**
Certification	**N/A**
Other Requirements or Standards	**Items/services must be of sufficient quality and appropriate to the needs of the consumer. The Consumer must provide a receipt for the purchase.**
Describe Service Delivery Method	**Consumer-Directed**

(Agency or Self-directed)	

B. ASSURANCES THAT REQUIREMENTS ARE MET

1. The state assures that standards, and/or applicable state licensure or certification requirements are met for services or for individuals furnishing services provided under the waiver.
2. The state assures that each service furnished under the waiver is cost-effective (compared to the cost of institutional care) and necessary to prevent institutionalization. Cost-neutrality is demonstrated in Appendix G.

C. FREEDOM OF CHOICE

The state assures that each individual found eligible for the waiver will be given free choice of all qualified providers of each service included in his or her written plan of care.

APPENDIX C – INTENTIONALLY LEFT BLANK

APPENDIX D - ENTRANCE PROCEDURES AND REQUIREMENTS

APPENDIX D-1

a. QUALIFICATIONS OF INDIVIDUALS PERFORMING INITIAL EVALUATION

Persons performing initial evaluations of level of care for waiver applicants will have the following educational/professional qualifications:
Physicians (M.D. or O.D.)

b. PROCESS FOR LEVEL OF CARE DETERMINATION

The following describes the process for evaluating and screening waiver applicants to determine level of care:
The Physician will document the level of care on the attached form (Attachment D1- FL-2 form) which will be submitted to the contract agency for prior authorization review. The attached level of care review criteria (Attachment D2) are used by the contract agency to determine eligibility for the recommended level of care. (Prior to initiating the process above, approval must be obtained from DMA to use another service "slot", i.e., add another person to the program. Program growth is closely monitored by the Medicaid agency due to State budgetary restrictions.)

c. CONSISTENCY WITH INSTITUTIONAL LEVEL OF CARE
The state will use the following methods to ensure that level of care determinations used for the waiver program are consistent with those made for institutional care under the State plan:
The review criteria in Attachment D2 are used for both facility and waiver level of care eligibility.

APPENDIX D-2

a. REEVALUATIONS OF LEVEL OF CARE

Reevaluations of the level of care required by the individual will take place (at least annually) according to the following schedule:
Reevaluation at least every 12 months (or sooner if there are indications that the person's condition/level of care has changed).

b. QUALIFICATIONS OF PERSONS PERFORMING REEVALUATIONS

Persons performing reevaluations of level of care will have the following qualifications:
Same qualifications as those performing initial evaluations.

c. PROCEDURES TO ENSURE TIMELY REEVALUATIONS

The state will employ the following procedures to ensure timely reevaluations of level of care:
Care advisor will be responsible for assuring timely reevaluations.

APPENDIX D-3

a. MAINTENANCE OF RECORDS

1. Records of evaluations and reevaluations of level of care will be maintained in the following location(s):
The care advisor and the contract agency which performs level of care reviews (currently EDS) maintain records.

2. Written documentation of all evaluations and reevaluations will be maintained as described in this Appendix for a minimum period of 3 years.

b. COPIES OF FORMS AND CRITERIA FOR EVALUATION / ASSESSMENT

A copy of the written assessment instrument(s) to be used in the evaluation and reevaluation of an individual's need for a level of care indicated in item 2 of this request is attached to this Appendix. If this instrument differs from the form used to evaluate or assess institutional level of care, a description of how and why it differs and an assurance that the outcome of the determination is reliable, valid, and fully comparable is attached.
(See Attachment D1)

APPENDIX D-4

Requirements regarding hearings and appeals procedures can be found in the State Medicaid Manual at Section 2901 and 2902.

a. FREEDOM OF CHOICE AND FAIR HEARING

1. When an individual is determined to be likely to require a level of care provided in an institutional setting, the individual or his or her legal representative will be:

a. informed of any feasible alternatives under the waiver; and

b. given the choice of either institutional or Home and Community-Based services.

PROCESS: The following describes the agency's procedure(s) for informing eligible individuals of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services:
Individuals seeking nursing facility services are informed of the availability of the waiver program as part of the eligibility process at the county departments of social services and by case managers/care advisors representing the waiver program lead agencies. Information about the waiver program is also disseminated through hospital discharge planners, home care agencies and advocacy groups. The individual is informed of the feasible alternatives under both CAP/DA and CAP Choice and provided the choice of either waiver participation or institutional care. The individual's choice is documented on the Plan of Care form, Attachment D3.

2. The agency will provide an opportunity for a fair hearing under 42 CFR Part 431, subpart E, to individuals who are not given the choice of home or community-based services as an alternative to the institutional care or who are denied the service(s) of their choice, or the provider(s) of their choice.

PROCESS: The following describes the process for informing eligible individuals of their right to request a fair hearing under 42 CFR Part 431, Subpart E:
When the individual is assessed for waiver services and advised of alternatives under the waiver, the individual is given appeal rights, which are documented on the Plan of Care form, Attachment D3. The individual is also notified of appeal rights anytime an adverse action is proposed. Attachment D4 is a sample notice of termination from the waiver program which illustrates appeal rights provided with all notices of adverse actions.

b. FREEDOM OF CHOICE DOCUMENTATION

1. A copy of the form(s) used to document freedom of choice and to offer a fair hearing is attached to this Appendix. **Attachment D3**

2. Copies of free choice documentation are maintained in the following location(s):
Client files maintained by Lead Agencies.

APPENDIX E - PLAN OF CARE

APPENDIX E-1 - PLAN OF CARE DEVELOPMENT/MAINTENANCE

1. The ~~attached~~ policy and procedures **below** define and guide the family or person-centered planning process and assure that families are integrally involved in the plan development and that the plan of care reflects their preferences, choices, and desired outcomes:

   This waiver program will be implemented on a pilot basis and participating counties will be selected through a *Request for Proposals* process aimed at identifying local agencies with the capacity to launch consumer-directed care. A workgroup consisting of consumers, advocates, State DHHS staff and other stakeholders, have been involved throughout the waiver planning process and developed a set of guiding principles and consumer and worker rights and responsibilities as a foundation for the program. The same basic care planning process currently used in the elderly/disabled hcbs waiver, CAP/DA, will apply to CAP Choice except that the process will be guided by principles of consumer-directed care. The steps in the entry process are:

   1. **During the intake process, a care advisor or case manager knowledgeable of consumer-directed care provides information on both the traditional and consumer-directed care program and the applicant decides which program he/she wishes to pursue.**
   2. **A registered nurse and social worker team meet with the applicant/significant others to conduct an assessment and determine the need for a representative.**
   3. **The care advisor assists the applicant in developing a plan of care including both unpaid and paid services, and calculates the consumer budget according to requirements in Appendix H.**
   4. **The care advisor submits the Plan to the designated position in the lead agency for approval.**
   5. **Once approval is obtained, services are implemented by the care advisor or consumer, as specified in the Plan.**

   The care advisor is available to the Consumer throughout the planning and service delivery process to provide skills training and information relevant to home care, worker employment, etc. The amount of assistance from the advisor will vary from consumer to consumer depending upon need. Consumers, care advisors, and all others who participate in developing plans of care and delivering services and supports will conduct these processes according to the following guiding principles:

CONSUMER DIRECTED CARE - GUIDING PRINCIPLES

These guiding principles are intended to apply to persons with disabilities and/or long term illnesses regardless of age, including minor children and their parents or guardian(s) as well as older adults in need of long term care services and supports.

PEOPLE WITH DISABILITIES AND LONG-TERM ILLNESSES:

- **have the same needs, hopes, desires and feelings common to all people.**
- **are entitled to the full benefits of community membership and citizenship, including all of its rights, privileges, opportunities, and responsibilities.**
- **must be afforded the dignity of taking risks.**
- **must have access to coordinated services and supports, determined by the individual's unique strengths, needs, and choices.**
- **must have the opportunity to direct the planning, selection, implementation, and evaluation for their services and supports.**
- **are the primary decision makers in their lives and must be supported and encouraged to achieve their full potential and be afforded the opportunity to develop personal relationships, learn, work and produce income, worship and be full participants in community life.**

COMMUNITY SERVICE & SUPPORT SYSTEMS MUST STRIVE TO:

- **provide safeguards to ensure personal security and well being and affirm and protect individual legal and human rights.**
- **be coordinated and person and family-centered; developed around the individual's needs and strengths, capabilities, and choices.**
- **be fully accessible, culturally responsive and provided in the most integrated community setting appropriate to the individual's needs and desires.**
- **support the development of informal and generic community resources that are accessible and readily available, and employ specialized services only when those used by the general public cannot reasonably accommodate the needs of the individual/family.**
- **be directed toward the enhancement of quality of life and the achievement of interdependence/independence, contribution, and meaningful participation in the community.**
- **support persons with disabilities and long term illnesses as the primary decision makers in their lives by providing the information and supports necessary to make informed decisions.**
- **reflect best practice, be cost-effective, efficient, and achieve outcomes valued by persons with disabilities and long term illnesses.**
- **be responsible stewards of public dollars, distributing resources to assure that individuals are served equitably and according to need and comply with all accountability requirements governing public funds administered by the system.**
- **ensure that consumers or their designated representative meet the responsibilities they agree to assume with regard to directing their own care including making informed and cost-effective decisions regarding services and supports.**

2. The following individuals are responsible for the preparation of the plans of care:
   The Consumer and the Care Advisor.

3. Copies of written plans of care will be maintained for a minimum period of 3 years in the following location(s):
   Lead agencies responsible for local oversight of the program.

4. The plan of care is the fundamental tool by which the state will ensure the health and welfare of the individuals served under this waiver. As such, it will be subject to periodic review and update. These reviews will take place to determine the appropriateness and adequacy of the services, and to ensure that the services furnished are consistent with the nature and severity of the individual's disability, and responsive to the individual's needs and preferences. The minimum schedule under which these reviews will occur is:
   Every 12 months.

5. The plan of care will contain, at a minimum, the type of services to be furnished, the amount, the frequency and duration of each service, and the type of provider to furnish each service.

6. If the state uses a standardized plan of care document, a copy of this form should be submitted.
   Attachment D3.

APPENDIX E-2 – MEDICAID AGENCY APPROVAL

The following is a description of the process by which the plan of care is made subject to the approval of the Medicaid Agency.

CAP Choice will operate alongside the traditional hcbs waiver program , CAP/DA, and the Plan approval process developed for that program will be adapted to CAP Choice. DMA has worked closely with lead agencies over the years to assure that they have the expertise and procedures in place to review and approve Plans and provide local oversight. Each lead agency has a designated position(s) with the authority to approve plans of care. The same process will be used for CAP/DA.

1) **An assessment is conducted by a nurse and social worker.**
2) **Based on assessment findings, the care advisor and applicant develop a plan of care.**
3) **The Plan and supporting documents are sent to the designated position within the local lead agency for review, and any clarifying information, questions or concerns are addressed by the care advisor.**
4) **The Plan is approved if program criteria are met, i.e.,**
    a. **Meets NF level of care**
    b. **Eligible for Medicaid**
    c. **Resides in geographic area where program is available**
    d. **Understands rights and responsibilities of consumer-directed care**
    e. **Suitable representative is available if required.**

5. **Subsequent plans of care are developed and approved through the same process.**

CAP Choice will initially be available only in a limited number of counties and will be selected through a request for proposal process. Those chosen to participate must demonstrate an understanding of and commitment to consumer-directed care and the capacity to implement consumer-directed plans and supports. Although local lead agencies will have the authority to make approval decisions on care plans, they will be required to submit copies to DMA for monitoring purposes. Submission of Plans to DMA will continue until DMA determines that this level of monitoring is no longer needed. CAP Choice care plans will then be monitored through CAP/DA quality assurance procedures, which include on-site program evaluations and record reviews at least every six months or more often at the discretion of the CAP/DA consultant during the pilot period for the waiver.

APPENDIX E-3 – PLAN OF CARE MANAGEMENT

The following is a description of the process and parameters within which families or individuals have flexibility to utilize resources identified within the plan of care and the individual budget that do not necessitate a formal revision to the plan of care. In addition, the state's infrastructure to support families or individuals in directing and managing their plan of care is described here.

PLAN OF CARE FLEXIBILITY: The Consumer will have the flexibility to substitute consumer-directed services, with the exception of Consumer-Designated Goods and Services, within the Plan as long as the change remains consistent with the needs, goals and objectives identified during the care planning process. When substitutions are

made, the client must notify the care advisor or FM. Consumer-directed services consist of Home Mobility Aids, Personal Assistant Services, In-Home Respite, Waiver Supplies, and Consumer Designated Goods and Services. Using funds to purchase Consumer-Designated Goods and Services will require a Plan of Care revision. In emergency situations, the care advisor may provide verbal approval prior to making the Plan revision.

INFRASTRUCTURE: The State began laying the foundation for implementing programs of consumer-directed care over a year ago when awarded a Real Choice Systems Change grant by CMS. The grant was requested to improve the quality of the State's direct care workforce and to make changes within the system that would promote increased consumer direction and choice. When the grant was awarded, a workgroup on consumer directed services, including consumers, providers, NC Department of Health and Human Services staff, consumer advocates and other stakeholders, was formed and has been meeting regularly since May 2002. The Workgroup has adopted a set of "Guiding Principles" for consumer-directed care; has agreed upon rights and responsibilities of consumers and workers; and is making recommendations on minimum standards that would apply to programs of consumer-directed care. NC DHHS, through this Workgroup, is in the process of releasing a request for proposals from local agencies that provide home and community based services and who are interested in piloting the consumer-directed service delivery option. Small grants will be awarded to the pilot sites to support local systems change, for example, to train staff in shifting from case management to consultants; to develop training materials for consumers who opt for consumer-directed care; or for building community partnerships that would facilitate consumer directed service delivery. Pilot agencies will be selected based on their capacity to develop local systems where consumers have maximum choice and control, which assure accountability, and which are designed to operate efficiently. The CAP/DA lead agencies, which are responsible for the local operation of the traditional hcbs waiver program for elderly and disabled adults, will be eligible to submit proposals, and it will be these agencies that launch the new waiver program. Thus, the State is being planful and inclusive in its efforts to implement consumer-directed care by building on a case management infrastructure that supports CAP/DA. All interested parties and stakeholders have been involved in planning the systems change, and efforts have been made to ensure that the most qualified and experienced home care entities are available to launch the initiative.

APPENDIX F – QUALITY ASSURANCE AND IMPROVEMENT

APPENDIX F-1 - QUALITY ASSURANCE & IMPROVEMENT PROGRAM

A description of the state's quality assurance and improvement program is attached. This description includes state policies and procedures which describe the:

1) frequency of quality assurance activities;
2) domains/dimensions/assurances that will be monitored (e.g., access, person-centered service planning, provider capacity and capabilities, participant safeguards, participant rights, participant outcomes and satisfaction, etc.);
3) process of discovery (including sampling methodologies and whether or not information is collected from interviews with families/individuals in their community residences);
4) identification of the persons responsible for conducting quality assurance activities and their qualifications (including how families and individuals will be involved in the process of assessing and improving quality);
5) provisions for periodically reviewing and revising quality assurance policies and procedures when necessary;
6) provisions for assuring that all problems identified by the discovery process will be addressed in an appropriate and timely manner, consistent with the severity and nature of deficiencies and
7) system to receive, review and act upon critical events or incidents.

APPENDIX F-2 ANNUAL REPORTS

A summary of the results of the state's monitoring of recipient health and welfare and the continuous improvement of waiver program operations will be submitted annually, as part of the CMS approved reporting forms/process.

ATTACHMENT F1 – QA/QI PLAN:

Quality Assurance will begin at the local level with the Consumer, care advisor and local lead agency.

- **Consumer: In opting for self-directed care, the Consumer assumes responsibility for contacting the care advisor if the Consumer believes his/her home care needs are not being met and safety and well-being are compromised. The care advisor will make a home visit to evaluate and assist – follow-up will be immediate if the situation appears to be an emergency. Examples of situations that would trigger a Consumer report are: Personal Assistant repeatedly fails to show up as scheduled; Personal Assistant exhibits inappropriate behaviors or actions in the Consumer's presence; informal (non-paid) supports do not follow through with agreed upon assistance.**
- **The care advisor will:**
  - **Provide training to the Consumer/family on managing services. Orientation to the program is required and will cover consumer-directed care principles/philosophy, worker and consumer rights and responsibilities, and participation requirements. Additional training on topics such as worker recruitment, reimbursement/rate negotiations, communication and supervision, will also be available. Training may be informal, one-on-one, or conducted in a group setting.**
  - **Review the Consumer's account at least monthly to monitor service provision. If significant deviations in actual vs. planned spending are occurring, contact with the Consumer is made to determine if a problem exists.**
  - **Make monthly phone calls to the Consumer to inquire about any concerns or problems with service provision.**
  - **Conduct a home visit quarterly to review service provision with the Consumer. Reassessments and plans of care are conducted annually and will require home visits; these visits will count toward the quarterly visit requirement.**

- **DMA will:**
  - **Review Plans of Care. The pilot agencies will have approval authority but will initially submit copies of all Plans on which decisions have been made to DMA for monitoring.**

  - **Make on-site visits to review program activities. DMA waiver program consultants currently conduct annual on-site CAP/DA reviews which include staff interviews, home visits, record reviews and review of operating procedures. CAP Choice activities and operations will be incorporated into these reviews and visits will be made at least every six months during the pilot phase of this project. The monitoring visits will be expanded to include review of consumer accounts/funds disbursement against plans of care. A written report will be generated and corrective actions for any problems identified will be required. A summary report of findings and corrective actions will be submitted to CMS annually.**

- **DMA and the lead agencies will work together to develop and administer consumer surveys. Questionnaires will be sent to a random sample of consumers monthly along with a stamped, addressed return envelope. Performance of Personal Assistants, absences, turnover, supervision, concerns about any unmet needs and feedback on overall program operation are some of the areas that will be addressed. Findings from the surveys will be used for program improvement; any critical issues will be addressed immediately.**

APPENDIX G – FINANCIAL DOCUMENTATION

APPENDIX G-1
COMPOSITE OVERVIEW AND DEMONSTRATION OF
COST-NEUTRALITY FORMULA

LEVEL OF CARE: **NF**

Definitions:

(NOTE: A separate chart should be completed for every level of care in the waiver program. The state should also include a chart reflecting the weighted average of the combined levels of care offered in the program.)

Factor D Estimated annual average per capita Medicaid cost for Home and Community-Based Services for individuals in the waiver program.

Factor D' Estimated annual average per capita Medicaid cost for all other services provided to individuals in the waiver program. .

Factor G Estimated annual average per capita Medicaid cost for hospital, NF, or ICF/MR care that would be incurred for individuals served in the waiver, were the waiver not granted.

Factor G' Estimated annual average per capita Medicaid costs for all services other than those included in Factor G for individuals served in the waiver, were the waiver not granted.

Col. 1 Year	Col. 2 Factor D	Col. 3 Factor D'	Col. 4 Total: D+D'	Col. 5 Factor G	Col. 6 Factor G'	Col. 7 Total: G+G'	Col. 8 Difference (subtract column 4 from column 7)
1	$17,489	$6,663	**$24,152**	$21,769	$3,873	**$25,642**	$1,490
2	$18,364	$6,996	**$25,360**	$22,857	$4,067	**$26,924**	$1,564
3	$19,282	$7,346	**$26,628**	$24,000	$4,270	**$28,270**	$1,642

If states elect to consider Supports Brokerage and/or Financial Management Services Services/Functions administratively rather than as wavier services, these costs and the methodology used to calculate the costs must be identified.
N/A The state considers both Care Advice (Supports Brokerage) and FM as waiver services.

Service	Estimated Costs	Methodology Description
Supports Brokerage		
Financial Management Services		

APPENDIX G-2 - DERIVATION OF ESTIMATES

NUMBER OF UNDUPLICATED INDIVIDUALS SERVED

YEAR	UNDUPLICATED INDIVIDUALS	EXPLANATION of ESTIMATE of NUMBER of UNDUPLICATED INDIVIDUALS SERVED:
1	200	**CAP Choice will be piloted in one or more (potentially three to six) counties or geographic areas of the State. The State is using a request for proposal process to identify pilot agencies/counties. A request to amend the waiver regarding the number served and expansion to other geographic areas may be submitted once the State has more experience with the new program.**
2	400	
3	600	
4		
5		

FACTOR D: AVERAGE COST OF WAIVER SERVICES YEAR 1

Waiver Service	# Users	Avg. Units/User	Avg. Cost/Unit	Total Cost
1 Adult Day Health	6	102 days	$36.51	$22,344
2 Care Advice	200	28 hours	$42.56	$238,336
3 Financial Management	200	12	$75.00	$180,000
4 Home Mobility Aids	26	1	$230.00	$5,980
5 In-Home Aide Services	125	12 hours	$13.92	$20,880
6 Personal Assistant Services	185	1320 hours	$12.00	$2,930,400
7 Home Delivered Meals	10	131 days	$3.14	$4,113
8 Respite – In-Home	4	75 hours	$12.00	$3,570
9 Respite – Institutional	1	9 days	$113.91	$1,025
10 Telephone Alert	92	9 months	$29.67	$24,567
11 Waiver supplies	82	1	$325.00	$26,650
12 Consumer-Designated Goods & Services	100	1	$400.00	$40,000
GRAND TOTAL:				$3,497,865
TOTAL ESTIMATED UNDUPLICATED RECIPIENTS:				200
FACTOR D (Divide total by number of recipients)				$17,489
AVERAGE LENGTH OF STAY ON THE WAIVER				285 days

FACTOR D: AVERAGE COST OF WAIVER SERVICES YEAR 2

Waiver Service	# Users	Avg. Units/User	Avg. Cost/Unit	Total Cost
1 Adult Day Health	12	102 days	$38.34	$46,923
2 Care Advice	400	28 hours	44.69	$500,506
3 Financial Management	400	12	$78.75	$378,000
4 Home Mobility Aids	52	1	$241.50	$12,558
5 In-Home Aide Services	250	12 hours	$14.62	$43,848
6 Personal Assistant Services	370	1320 hours	$12.60	$6,153,840
7 Home Delivered Meals	20	131 days	$3.30	$8,638
8 Respite – In-Home	8	75 hours	$12.50	$7,497
9 Respite – Institutional	2	9 days	$119.61	$2,153
10 Telephone Alert	184	9 months	$31.15	$$51,590
11 Waiver supplies	164	1	$341.25	$55,965
12 Consumer-Designated Goods & Services	200	1	$420.00	$84,000
GRAND TOTAL:				$7,345,517
TOTAL ESTIMATED UNDUPLICATED RECIPIENTS:				400
FACTOR D (Divide total by number of recipients)				$19,364
AVERAGE LENGTH OF STAY ON THE WAIVER				285 days

FACTOR D: AVERAGE COST OF WAIVER SERVICES YEAR 3

Waiver Service	# Users	Avg. Units/User	Avg. Cost/Unit	Total Cost
1 Adult Day Health	18	102 days	$40.25	$73,903
2 Care Advice	600	28 hours	$46.92	$788,296
3 Financial Management	600	12	$82.69	$595,350
4 Home Mobility Aids	78	1	$253.58	$19,779
5 In-Home Aide Services	375	12 hours	$15.35	$69,061
6 Personal Assistant Services	555	1320 hours	$13.23	$9,692,298
7 Home Delivered Meals	30	131 days	$3.46	$13,605
8 Respite – In-Home	12	75 hours	$13.23	$11,907
9 Respite – Institutional	3	9 days	$125.59	$3,391
10 Telephone Alert	276	9 months	$32.71	$81,255
11 Waiver supplies	246	1	$358.31	$88,145
12 Consumer-Designated Goods & Services	300	1	$441.00	$132,300
GRAND TOTAL:				$11,569,289
TOTAL ESTIMATED UNDUPLICATED RECIPIENTS:				600
FACTOR D (Divide total by number of recipients)				$19,282
AVERAGE LENGTH OF STAY ON THE WAIVER				285 days

Please provide a narrative description and supporting documentation for the derivation of the following factors:

FACTOR D DERIVATION: Factor D is estimated based on utilization reflected in the CMS-372 report for the State's existing elderly/disabled waiver program. The most current report is ffy 2001; the ffy 2002 372 has not been finalized. The State anticipates that utilization of services will be very similar to that in the current program, except that participants will opt for consumer directed personal assistance rather than the traditional agency-based in-home aide service. Use of the agency based aide service is expected to be very low as it will most likely be accessed primarily for emergency back-up or on an interim basis.

FACTOR D' DERIVATION: Factor D' is estimated based on utilization reflected in the CMS-372 report referenced above for the State's existing elderly/disabled waiver program. Utilization of non-waiver Medicaid services is expected to be about the same as the populations are identical, i.e., the same age groups and level of care.

FACTOR G DERIVATION: **The CMS-372 is generated by a computer run which also contains utilization and expenditures for Medicaid recipients in nursing facilities. Facility costs are estimated based on the actual cost of nursing facility care reflected in this report.**

FACTOR G' DERIVATION: **The CMS-372 is generated by a computer run which also contains utilization and expenditures for Medicaid recipients in nursing facilities. G' is estimated based on the actual cost of non-facility, Medicaid services for people in nursing facilities.**

Appendix G-3 METHOD OF PAYMENTS (check one):

__X__ Payments for all waiver and State Plan services will be made through an approved Medicaid Management Information System (MMIS).

____ Payments for some, but not all, waiver and State Plan services will be made through an approved MMIS. A description of the process by which the state will make payments and maintain an audit trail is attached to this Appendix.

_____ Payment for waiver services will not be made through an approved MMIS. A description of the process by which the state will make payments and maintain an audit trail is attached to this Appendix.

Appendix G-4 – INDIVIDUAL BUDGET PROJECTIONS OF RESOURCES WITHIN THE EXCLUSIVE CONTROL OF THE FAMILY OR THE INDIVIDUAL. (This information is required, but will not be used in the calculations of cost-neutrality.)

Please estimate the proportion of families or persons who will have annual individual budget amounts within their control in the following ranges:

Budget Range	Proportion of Participants
$1 – 5,000	
$5001 – 10,000	10%
$10,000 – 15,000	35%
$15,001 – 20,000	45%
$20,001 – 25,000	10%
$25,001 – 50,000	
$50,000 – 75000	
$75,001 – 100,000	
$100,000 and above	
	100%

APPENDIX H – INDIVIDUAL BUDGETS

The following describes in detail EITHER:

The state's uniform methodology for the calculation of individual budgets, OR

The criteria and approval process for entities with which the state has contracted for day-to-day operations of the program.

This description addresses the minimum requirements that the methodology employ actual service utilization and cost data, how the methodology is explained to the family or individual, the re-determination process, and how the methodology is made open to public inspection.

Methodology for Calculation of Individual/Consumer-Directed Budget:

Budgets will be calculated based on the methodology in place for the CAP/DA waiver currently serving the elderly/disabled. The process involves an assessment to identify needs; development of goals based on identified needs; and agreement on the type and amount of services needed to meet the goals. The estimated monthly cost of each service is calculated. The cost of all services cannot exceed the average per capita cost to Medicaid of nursing facility care.

The budget will contain both agency and consumer-directed services, as outlined below. Those designated as consumer-directed will constitute the individual budget to be directed by the consumer.

Agency-Directed	Consumer-Directed
Adult Day Health Care	**Consumer-Designated Goods & Services**
Care Advice	**Home Mobility Aids***
Financial Management	**In-Home Respite***
In-Home Aide	**Personal Assistant**
Institutional Respite	**Waiver Supplies***
Preparation & Delivery of Meals	
Telephone Alert	
***Indicates service may be either consumer or agency directed**	

It is recognized that actual utilization of services authorized does not equate to 100% - for example, consumers are hospitalized, aides miss visits and substitutes are not available. Based on findings of the national Cash & Counseling demonstration, at least 10 to 20% of personal care services authorized in the traditional delivery system are not used. In addition, many of the indirect costs which are built into the payment rates such as professional supervision and training of workers, office space, equipment, supplies, etc., are not applicable to the consumer-directed model. Therefore, the maximum hourly rate for Personal Assistant services will be10 to 20 percent lower than the current Medicaid Personal Care rate. Individuals may negotiate Personal Assistant payment rates lower than the maximum, thereby enabling them to set aside a portion of their budget through the Financial Manager for Consumer-Designated Goods and Services (non-traditional goods and services which increase independence, as described in Appendix B). A sample budget follows ("AD" & "CD" designate "agency-directed" and "consumer-directed", respectively). The unit costs are examples only:

SERVICE	AMOUNT	UNIT COST	MONTHLY COST	METHOD
Care Advice	2 H/Mo	$42/H	$84.00	AD
FM Service	N/A	$100/M	$100.00	AD
Personal Asst.	6 H/D, 7D/W	$10/H*	$1806.00	CD
Waiver Supplies (Nutr. Supp.)	30 cans/M	$2/Can	$60.00	CD
Home Mob. Aid (Widen Doorway)	N/A	$250	$20.83 (prorated)	CD
Consumer-Designated Service (Rex Hospital Wellness Program)	Monthly membership	$50/M	$50.00	CD
Total Cost			$2120.83	
Total CD Budget			$1936.83	

***Current Personal Care payment rate $13.92 x 85% (utilization factor) = $11.83 hourly maximum; consumer-negotiated rate = $10.00/hour.**

Participants will have considerable flexibility in using funds designated as consumer-directed. They will be able to substitute services and/or reschedule services within the CD budget without agency approval in most cases (adding/substituting Consumer-Designated Goods and Services requires agency approval).

The methodology above will be explained by the care advisor. The care advisor will point out both the added responsibilities if this model is selected and its benefits. The Individual/Consumer-Directed Budget will be re-determined at least annually and more frequently depending on changes in the Consumer's situation.
The methodology will be published in the operations manual for this program. All Medicaid policy and program manuals are available for public inspection.

APPENDIX I – PARTICIPANT PROTECTIONS

The state procedures and processes to assure that each of the following protections is in place are described below.

The state has procedures to assure that families and individuals have the requisite information and/or tools to participate in a family or person-centered planning approach and to direct and manage their care as outlined in the individual plan of care. The state will make available and provide services such as assistance in locating and selecting qualified workers, training in managing the workers, completing and submitting paperwork associated with billing, payment and taxation. Such functions are mandatory under the template and should be provided by one or more entities. When these functions are delivered as waiver services the provider qualifications are described in Appendix B.
The lead agency will give each hcbs waiver applicant a choice between the traditional program and the new consumer-directed model. The care advisor will provide information to consumers opting for CAP Choice on worker qualifications and suggest recruitment alternatives if the Consumer does not have a worker in mind. The advisor will provide skills training on interviewing, supervising and evaluating workers and will assist with these activities if desired by the Consumer. All consumer accounts and funds disbursement will be handled by the FM. The FM will provide information and instructions on authorizing payment for Personal Assistant services and other consumer-directed services and assure that the necessary payroll deductions are taken. The care advice and FM services are waiver services and provider qualifications are described in Appendix B.

Upon family or individual request, the state will make available at no cost, provider qualification checks, including criminal background checks.
The Financial Manager will conduct provider and criminal background checks.

The state must have procedures to promote family or individual preferences and selections. These are appropriately balanced with accepted standards of practice. This balance requires deference to the preferences of the individual whenever possible. Procedures may include individual risk management planning (e.g., risk agreements or informed consent contracts) to ensure that family or individual decisions are honored.

Consumers will be fully involved in the needs assessment process and will select Personal Assistants based on their (vs. agency) preferences. As indicated in Appendix B, the Consumer will train the Assistant and determine whether task competencies are met. In assuming these responsibilities, the Consumer necessarily takes on risk that was previously assumed by provider agencies and program managers. Consumers who participate in this program will therefore enter into agreements with the lead agencies which outline rights, risk and responsibilities.

The State has a system in place for assuring emergency back up and/or emergency response capability in the event those providers of services and supports essential to the individual's health and welfare are not available. While the state may define and plan for emergencies on an individual basis, the state also must have system procedures in place.

The lead agency will make arrangements with local licensed home care agencies to provide temporary in-home aide assistance on short-notice and when Personal Assistants are unexpectedly unavailable. In addition, the care advisor will work

with each Consumer during the care planning process to identify informal (unpaid) supports who could assist in emergency situations. Contact information for these emergency supports will be included in the plan of care .

The state has procedures for how it will work with families and their employer agents (if applicable) to monitor the ongoing expenditures of the individual budgets.

The care advisor will monitor expenditures on a monthly basis through review of Consumers' individual accounts maintained by the FM.

The state has procedures for how it will handle those instances where this ongoing monitoring has failed to prevent the expenditure of the individual budget in advance of the re-determination date. These procedures are to assure that services needed to avoid out-of-home placement and the health and welfare of the individual are available.

Documentation that services have been provided, particularly in the case of Personal Assistant services, will be required before the FM pays the provider. In addition to monthly monitoring of funds expended by the Care Advisor, the FM will alert the care advisor to significant overspending.

The state has procedures for how decisions will be made regarding unexpended resources at the time of budget re-determination.

Unexpended resources in consumer accounts will consist of funds for consumer-directed services billed by the FM but not disbursed. Examples of non-disbursed funds would be unexpected absences of Personal Assistants, supplies purchased at a lesser rate or quantity than anticipated, etc. Excess funds can remain in the account and be used by the Consumer for additional home care services if needed until the annual continued needs review. At that time, the care advisor will coordinate with the FM Entity to see that the State Medicaid program is reimbursed.

The state has a system by which it receives, reviews and acts upon critical events or incidents (states must describe critical events or incidents). This system may include an existing process (e.g. child or adult protective services). This system must be part of the Quality Assurance and Improvement Program.

As described in the QA/QI section, critical events or incidents involving plan of care failure (e.g., Worker continually absent) will be addressed by the care advisor. Problems which are non-plan of care related such as neglect by caretaker or exploitation will be referred to Adult Protective Services for investigation as required by State law.